Implications of Social Class for Public Health

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This paper[1] will consider three areas in which social class and status have important implications for public health: 1) The differential distribution of disease and consequent evaluations of appropriate foci of public-health interest and activity; 2) The functioning of interpersonal relations within the health team and between team and public; 3) The congruence between public-health precepts and felt needs of the public at whom these precepts are directed.

For present purposes, "status" and "class" will be employed as generic terms, the former to refer simply to rank, or relative position in a status hierarchy, and the latter to refer to a group of individuals who occupy a broadly similar position in a status hierarchy. When the term "class status" is used, it refers to membership in a given stratum of a status hierarchy, whether this stratum be a statistical aggregate or a real group. When class value differences are discussed in terms of middle-class and lower-class, the reference is to modal types which higher and lower status people may manifest in different degrees; it does not necessarily follow that all higher status people adhere to the middle-class modal type, and all lower status people to the other. Presumably, many members of both these strata may not incorporate the corresponding class values and may deviate from the modal type in other respects. It may be noted that the character of modal types is determined by common economic and power situations and cultural experiences, which offer more or less similar life chances or opportunities. In discussing interpersonal relations, the primary focus will be on the ways in which orientations to relative status affect the functioning of a given relationship. In discussing congruence and divergence between public-health precepts and felt needs of the public, the primary focus will be on modal subcultural types.

I

Like the social welfare movement, the public-health movement has been conceived and implemented primarily by middle-class people, and directed primarily at lower-class people. As in most social movements, the public-health movement was mainly activated by motives of social uplift and self-protection. The conclusion, in 1830, that if cholera were not stamped out it might move from the slums to within the middle-class gates led to a sudden increase in interest in public health both in Europe and the United States. According to Shryock, "Fear now combined with humanitarianism to demand investigations, cleanups, and general sanitary reform."[2]

Public health has traditionally focused on the control of the mass diseases which, by and large, have had their greatest incidence and prevalence among the lower-classes, as, e.g., smallpox, typhus, typhoid, the nutritional deficiency disorders, and tuberculosis. With increasing control of these diseases, new mass diseases, such as the cardiovascular disorders and poliomyelitis, have claimed not only the attention of public-health personnel but have excited great public interest among our higher status groups as well, as currently reflected in the great annual fund-raising drives.[3] Taking as a specific case the contrast between polio and tuberculosis, we find that when the treatments for the latter were developed, professional interest far exceeded public interest; yet, when the Salk polio vaccine was developed, public interest far exceeded professional, and Salk became a national hero. There is an inverse correlation between degree of public interest and incidences connected with these two diseases. Polio rates are relatively low compared to those of other mass diseases, and tuberculosis rates continue relatively high.[4]

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1. Revised version of a paper read at the 1955 annual meeting of the American Anthropological Association, Boston, Mass.

2. R. H. Shryock, *The Development of Modern Medicine: An Interpretation of the Social and Scientific Factors Involved.* New York, Knopf, 1947.

3. The writer is indebted to Dr. Edward Wellin for suggesting this instance of class differentials in disease, and in particular for bringing out the significance of the contrast between tuberculosis and polio.

4. National figures for three sample years are as follows (from the Massachusetts Bureau of Health Information):

	Poliomyelitis		*Tuberculosis*	
Year	Cases	Deaths	Cases	Deaths
1940	9,804	1,026	102,984	60,428
1945	13,624	1,186	114,931	52,916
1950	33,330	1,686	121,742	33,633

This striking difference between polio and tuberculosis may be regarded in large part as a function of class distributions and perceptions of disease.[5] Tuberculosis, like many of the older mass diseases, is primarily identified with lack of personal and environmental hygiene, poverty, overcrowding, and malnutrition, but in the case of polio, as in that of the cardiovascular ailments, no such identification has been established. In fact, there is some evidence to indicate that higher polio rates are to be found among those who enjoy quite the opposite set of conditions.[6] Tuberculosis and polio are both public threats, but the crucial difference here seems to be that tuberculosis is pretty well confined to our lower status groups, while polio is within the middle-class gates.

II

The practice of public health is carried on within two main interpersonal relations systems, the intrateam and team-public systems. Participants in either system may be members of the same or different societies, but in either case, class, as it refers to subcultural differences, may add an important dimension. Although there has been some research on interpersonal relations in the practice of clinical medicine and psychiatry, investigations in the public-health field have scarcely yet gone beyond impressions and casual observations. We will consider here only a few of the possibilities in intrateam relations in the intercultural situation, and in team-public relations in the intracultural situation.

The most common instance of public-health teams where members belong to different societies is to be found in technical assistance programs in "underdeveloped" countries. In this intercultural situation, class considerations can minimize or enhance major cultural differences that obtain between team members. With regard to class factors that serve to reduce cultural differences, it has been noted that class cultures tend to go beyond societal boundaries. As Saunders has pointed out, an upper-class Mexican American may feel more at ease with an upper status Anglo American than with a lower-class Mexican American in a situation involving some degree of intimacy, since their awareness of cultural group distinctions is minimized, even though it may not be entirely superseded by their social class identification.[7] In Latin America, upper-class groups in different countries, due to similar positions of dominance, possession of power and wealth, and the common experience of travel and education in Europe and America, tend to have value systems which not only approximate those of higher status Americans, but are more similar to each other than to those of lower-class Latin Americans in their respective countries.

With regard to the role of class factors in enhancing cultural differences among team members, it may be that, despite the cross-societal bond, tensions will be engendered, e.g., between Americans and their local collaborators because of failure of the American to understand and acknowledge what may often be substantial differences in status between the two relative to their own class hierarchies. Thus, in contrast to the American, who will only in the rare case be descended from a top status family and have held a high-level position in his own country, local collaborators are likely to be members of ruling class families and to occupy high-ranking positions in their government's ministry of health. Americans, by virtue of their tendency to play down class differences, as well as of pronounced ethnocentric tendencies, are not likely to manifest overtly the degree of respect for their collaborators which the latter may expect as their due. For the same reasons, they are likely to reject or ignore the subordinating and deference devices traditionally used by upper-class people in conducting their relations with lower status people in those countries where status differences are generally explicitly acknowledged and taken for granted. One of the most pervasive grievances nursed by upper-class people abroad with respect to Americans concerns the latter's treatment of servants as near-equals by giving them the same food, paying them "too much," and so on.

Ideally, the doctor's role in the therapeutic relationship focuses on his performance of a technical specialty, on his impartially serving the patient's health needs independently of whether he likes the patient as a person, and on his obligation to give priority to the patient's well-being over his own personal interests. This ideal seems to hold across the board in most Western societies, although it may not always hold in non-Western societies.[8] This role definition is calculated to inspire trust, respect, and confidence between doctor and patient, and thus insure cooperation. In practice, however, it seems that the ideal is seldom approximated in professional-patient relationships, and that it is precisely in the doctor-patient relationship where it is least likely to be achieved.

Studies in intracultural situations, both here and in other societies, indicate a tendency for class considerations to over-

5. The role of class factors in these contrasting public reactions seems clear, but obviously there are always other variables associated with specific diseases that play some part as well. In the case of tuberculosis and polio, there may be, e.g., differences in dramatic impact and publicity. Polio has physically visible after-effects, although this must be compared with the social visibility associated with tuberculosis. Also, any disease, like polio, that tends to victimize children in disproportionately large numbers seems to excite more public reaction. However, in view of the great overlap in age between those who contract the two diseases, it is difficult to say what part this factor may actually play in determining public attitudes. Although comparable information for tuberculosis is lacking, the importance of class factors in evaluating polio is borne out by Deasy's findings regarding participation in the 1954 polio vaccine field trials, namely that upper status mothers were much more likely to have taken previous precautions against the disease, knew more about the trials, and demonstrated a higher awareness of the disease entity itself. See Leila C. Deasy, "Socio-Economic Status and Participation in the Poliomyelitis Vaccine Trial." *American Sociological Review,* 21:185-191, 1956.

6. Paffenbarger and Watt, in their epidemiological study of polio in South Texas, report that "groups of individuals living under better economic circumstances with the many associated 'advantages' of greater personal cleanliness, less crowding, better food, and less association with verminous insects may suffer a significantly higher attack rate to the paralytic disease and suggests that . . . for the United States [this] is somehow related to an improved standard of living." Ralph S. Paffenbarger, Jr., and James Watt, "Poliomyelitis in Hidalgo County, Texas, 1948: Epidemiological Observations." *The American Journal of Hygiene,* 58:269-287, 1953.

7. Lyle Saunders, *Cultural Difference and Medical Care.* New York, Russell Sage Foundation, 1954.

8. Cf. McKim Marriott, "Western Medicine in a Village of Northern India," *in* Benjamin D. Paul (ed.), *Health, Culture, and Community: Case Studies of Public Reactions to Health Programs.* New York, Russell Sage Foundation, 1955, pp. 239-268.

shadow therapeutic considerations in the professional-patient relationship. It appears that the degree to which the qualities ideally defined as essential to the therapeutic relationship, namely mutual trust, respect, and cooperation, will be present in a given professional-patient relationship varies inversely with the amount of social distance. Conversely, the greater the social distance, the less likely that participants will perceive each other in terms of the ideal type roles of professional and patient, and the more likely that they will perceive each other in terms of their social class status in the larger society.

The therapeutic relationship should function at its optimum where professional and patient are of the same class status. Studies of the psychotherapeutic relationship in this country indicate that the patients who most nearly approach the therapist's status are accorded the best treatment and the most sympathy.[9] In the public-health context, it is possible that, although professionals may deem it easier to relate to patients who are of the same class status, higher status patients may reject the health worker not because of his class status as such but because they perceive his attempts to serve them at all as identifying them with the lower status people typically served by public health, and thus regard him as a threat to their social position. In a Peruvian village, an auxiliary health worker was rejected by higher status people because "she was perceived as equating them with the unwashed and uneducated poor."[10] In Chile, nurses in a health center were extremely reluctant to approach middle-class families in their sectors because they anticipated a poor reception.[11]

In public health, where the typical case is that of higher status professional and lower status patient, the available evidence indicates that doctors and patients do not "get along" as well as do nurses and patients, but this need not mean that the respective class statuses of doctor, nurse, and patient are the sole or even principal factors in determining the difference in quality of doctor-patient and nurse-patient relations. Such factors as differences in professional training and expected role performances must also be weighed.[12]

In attempting to specify the varying roles that class perceptions and values may play in the functioning of professional-patient relations, it would be worthwhile to investigate whether status considerations loom larger for the professional or for the patient. In Regionville, e.g., there was considerable feeling on the part of lower status people that physicians did not want them as patients.[13] On the other side, some of the factors that influence professionals to inject status considerations into their relations with patients may be related to the professional's orientations to upward mobility. In Colombia, e.g., the cities have been flooded by rural immigrants who no longer classify themselves according to the traditional status system. As a result of the competition to rise socially, individuals with some small position of authority press their weight on others to force a recognition of their status. Thus, doctors and nurses in the Colombian government health centers are often overbearing in their treatment of the public.[14]

III

To the extent that it may be characterized as a social movement, public health has inevitably incorporated the dominant middle-class values of our society, primarily those that stem from the "Protestant ethic" core.[15] It follows that public-health precepts are formulated in terms of these values, and applied on the assumption that they are universally meaningful and desirable. However, class differences may set substantial limits to the degree of congruence possible between these precepts and the felt needs of a lower-class public.[16] We may ask: 1) To what extent do public-health workers apply their middle-class norms in working with lower status groups? 2) Are lower-class norms significantly different in those areas where middle-class norms are imposed? 3) If there are such points of difference, how relevant are they for the effective functioning of public-health activities?

Lower status families are beset by greater economic insecurity than higher status families, and their "scientific" knowledge about modern medicine is apparently less extensive than that of higher status people, but beyond these reality factors, classes also vary in their behavioral characteristics and value orientations.

In view of the prominent public-health emphasis on personal and environmental hygiene, possible class differences in the importance attached to cleanliness is an area that readily comes to mind. For middle-class people, cleanliness is not simply a matter of keeping clean but also an index to the morals and virtues of the individual. It has been frequently observed that middle-class valuations of cleanliness approach compulsive proportions, and that lower status people are much more casual in this matter. It is possible that the stress placed on cleanliness in health education and other public-health activities far overshoots any felt needs in this area on the part of lower status people.

Middle-class norms place great emphasis on the ability to defer gratifications in the interest of long-run goals. Readiness to sacrifice the present for some possible gain in the future may not be nearly so pervasive a pattern among lower status people, who may accord priority to immediate rewards. This

9. Cf. Alan Grey, "Relationships between Social Status and Psychological Characteristics of Psychiatric Patients." Unpublished Ph.D. thesis, University of Chicago, 1949. See also F. C. Redlich, A. B. Hollingshead, and Elizabeth Bellis, "Social Class Differences in Attitudes toward Psychiatry." *American Journal of Orthopsychiatry,* 25:60-70, 1955.

10. Edward Wellin, "Water Boiling in a Peruvian Town," *in* Benjamin D. Paul (ed.), *op. cit.,* pp. 71-103.

11. Ozzie G. Simmons, *The Health Center of San Miguel: An Analysis of a Public Health Program in Chile.* Santiago, Institute of Inter-American Affairs, 1953.

12. See Ozzie G. Simmons, "The Clinical Team in a Chilean Health Center," *in* Benjamin D. Paul (ed.), *op. cit.,* pp. 325-348.

13. Earl L. Koos, *The Health of Regionville.* New York, Columbia University Press, 1954.

14. Charles J. Erasmus, "Changing Folk Beliefs and the Relativity of Empirical Knowledge." *Southwestern Journal of Anthropology,* 8:411-428, 1952.

15. This refers to public health not only in the United States but in all areas that have been importantly influenced by the British and American varieties of public health.

16. In the preparation of this section, the writer is indebted for suggestions to an address by Dr. Walter B. Miller entitled "Social Class: Its Influence on Health Behavior," delivered at the October, 1955 meeting of the Massachusetts Public Health Association.

suggests some questions with regard to the public-health emphasis on prevention. Is acceptance of the value of prevention contingent upon ability to defer gratification, and, if so, do lower-class norms in this area set limits to such acceptance? Are lower status people as willing, as higher status people may be, to inconvenience themselves by adoption now of practices aimed at avoiding possible consequences in the future?

Middle-class norms accord high value to rationality, as it refers to use of foresight, deliberate planning, and allocation of resources in the most efficient way.[17] This again places an emphasis on future time orientations that may not be particularly meaningful to lower status people. However, public-health teachings assume that this value does hold for lower status people when they emphasize the development of regular health habits and the expenditure of the domestic budget in ways best calculated to insure a balanced diet for the family.

Middle-class norms prescribe a strong sense of individual responsibility, which sets a high premium on resourcefulness and self-reliance. This value is frequently built into public-health goals. For example, the principal objective of health education is often expressed as the "inculcation in each individual of a sense of responsibility for his own health." This ideal pattern of individual responsibility can be contrasted with one of reciprocity, particularly within the family, that seems more characteristic of lower-class norms. The lower status individual may be much less likely to think that responsibility for his well-being rests solely with himself, and more likely to think that if something does happen, the kin group will see him through.

An individual's definitions of and responses to health and illness have import for a wide range of public-health problems, and these are usually class-linked. Throughout Latin America, e.g., lower status groups adhere to a vigorously functioning medical tradition which health workers and other medical people do not share.[18] The gulf is in part maintained by the health worker's rejection of this folk medicine tradition as "superstition," and in part by the fact that lower status people reserve for folk medicine a wide variety of illnesses defined as inaccessible to scientific medicine because doctors do not "know" them and therefore cannot cure them.

Finally, we may briefly consider class differences in child training patterns as these are relevant for public health. Middle-class socialization patterns tend to be consistently organized in accordance with the middle-class emphases or effort and achievement, which are thought to be good in themselves or good because they are instrumental to long-run goals and, as a consequence, the middle-class child is subjected to considerable close supervision and control.[19] On the other hand, lower-class socialization patterns are relatively easy-going, and allow the child much more latitude with respect to eating, sleeping, cleanliness, dress, work, school, and play. Lower status parents may be much more rigid about obedience but the imposition of authority is usually arbitrary and inconsistent. Maternal and child health programs are considered to be one of the most crucial in any large-scale public-health effort, and the mother is generally regarded as the most strategic person to reach in health education. Much of the education of lower status mothers seems to be based on the premise that the latter are as motivated in controlling and molding their children as are higher status mothers, and if this is not actually the case, it would mean that these teachings stand relatively less chance of being implemented. Moreover if lower-class socialization is so likely to be governed by the child's own inclinations, his parents' convenience, and fortuitous circumstances, it is probable that the health worker must cope with much greater variation in practices than he may be aware of.

IV

This discussion has considered three areas in which social class has important implications for public health. Social class differences are associated with the differential distribution of disease and consequent definitions of appropriate foci of public-health interest and activity, with variations in quality of interpersonal relations and the health team and between the team and the public it serves, and with divergences in goals and perceptions between the health worker and his client.

By virtue of the fact that the situation of action in the public-health field typically involves the higher status practitioner and lower status patient, class differences in realistic conditions, value orientations, and behavioral characteristics may have a substantial role to play in determining the outcome of public-health programs. Acceptance or rejection of the goods and services that public health has to offer in large part depends upon how these are perceived by the recipient. Such perceptions vary with one's class membership, and attempts to change them are likely to collide with the individual's investment in his group affiliations. A social class constitutes a membership group, and promoting and maintaining one's acceptance by the group calls for conformity with the perceptions and behavior deemed correct and desirable by the group, whether it be in relation to health and illness or anything else.

17. This and the following formulation of middle-class norms were suggested by a summary description of middle-class standards in Albert Cohen, *Delinquent Boys: The Culture of the Gang*. Glencoe, Free Press, 1955, pp. 89-90.

18. See Erasmus, *op. cit.;* George M. Foster, "Relationships Between Theoretical and Applied Anthropology: A Public Health Program Analysis." *Human Organization,* 11:3 (Fall, 1952), pp. 5-16; and Ozzie G. Simmons, "Popular and Modern Medicine in Mestizo Communities of Coastal Peru and Chile." *Journal of American Folklore,* 68:57-71, 1955.

19. Cf. Arnold W. Green, "The Middle-Class Male Child and Neurosis." *American Sociological Review,* 11:31-41, 1946.